

Registration District No. 200

Primary Registration District No. 5279 B

Registrar's No. 2

1. PLACE OF DEATH:  
 (a) County Clay  
 (b) City or town Rural Kearney Township  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If not in hospital or institution, write street number or location) 2  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME JOSEPH A. Odor 360  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Gerlie Odor 6. (c) Age of husband or wife if alive 55 years  
 7. Birth date of deceased November 13 1883  
 (Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Clay County Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Dudley Odor  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name Elizabeth Frick  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Joseph A Odor  
 (b) Address Kearney Mo R. 1

17. (a) Burial (b) Date thereof Jan 15 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arley Cemetery

18. (a) Signature of funeral director Arley Cemetery  
 (b) Address Kearney Mo

19. (a) Jan 24 1940 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Clay  
 (c) City or town Rural Kearney Twp  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 8 miles N.W. of Kearney  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23  
 year 1940 hour 11 minute 2 a.m.

21. I hereby certify that I attended the deceased from January 19, 1940 to January 23, 1940.  
 that I last saw him alive on January 23, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of lung

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. T. Rube mo (M. D. or other) \_\_\_\_\_  
 Address Smithville Mo Date signed 1-25-40

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 6-11-40

RECEIVED PUBLIC HEALTH DEPT.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed..... *C. W. Hessel*

Licensed Embalmer No. *3471*

P. O. Address... *Kearney Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18205

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 200

Primary Registration District No. 2279B

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Kennett, T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Joseph E. Odor

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 36 Months 2 Days 10 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Dudley Odor  
13. Birthplace Kentucky (City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Fries  
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1/24/40 (b) Phos L. Smith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U.S.A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. F. Rouse (M. D. or other) \_\_\_\_\_  
Address Smithville Mo Date signed 1/20/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH SUPPLEMENTARY

